

| | | | |
|---------------------------------|---|-------------------------------|--|
| <i>SERFF Tracking Number:</i> | <i>JEPL-125878999</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>The Lincoln National Life Insurance Company</i> | <i>State Tracking Number:</i> | <i>40938</i> |
| <i>Company Tracking Number:</i> | <i>TRM5065 ET AL</i> | | |
| <i>TOI:</i> | <i>L04I Individual Life - Term</i> | <i>Sub-TOI:</i> | <i>L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium</i> |
| <i>Product Name:</i> | <i>TRM5065 et al, LifeElements Level Term 2009</i> | | |
| <i>Project Name/Number:</i> | <i>/TRM5065 et al, LifeElements Level Term 2009</i> | | |

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: TRM5065 et al, LifeElements Level Term 2009 SERFF Tr Num: JEPL-125878999 State: ArkansasLH

TOI: L04I Individual Life - Term SERFF Status: Closed State Tr Num: 40938

Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium Co Tr Num: TRM5065 ET AL State Status: Approved-Closed

Filing Type: Form Co Status: Reviewer(s): Linda Bird
 Authors: Ray Fortier, James Kane, Jeanine Taylor Disposition Date: 11/25/2008
 Date Submitted: 11/21/2008 Disposition Status: Approved

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

| | |
|---|---------------------------------------|
| Project Name: | Status of Filing in Domicile: Pending |
| Project Number: TRM5065 et al, LifeElements Level Term 2009 | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Group Market Size: |
| Overall Rate Impact: | Group Market Type: |
| Filing Status Changed: 11/25/2008 | |
| State Status Changed: 11/25/2008 | Deemer Date: |
| Corresponding Filing Tracking Number: | |
| Filing Description: | |
| Hon. Julie Benafield Bowman | |
| Commissioner of Insurance | |
| Compliance-Life & Health | |
| Attn: Joe Musgrove | |

SERFF Tracking Number: JEPL-125878999 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 40938
Company Tracking Number: TRM5065 ET AL
TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium
Product Name: TRM5065 et al, LifeElements Level Term 2009
Project Name/Number: /TRM5065 et al, LifeElements Level Term 2009

1200 West Third Street
Little Rock, AR 72201-1904

Re: Individual Term Life Insurance Policy Forms
TRM5065; Term to Age 95 Life Insurance Policy
F5165-10; 10-Year Level Term to Age 95 Policy Data Pages
F5160-15; 15-Year Level Term to Age 95 Policy Data Pages
F5160-20; 20-Year Level Term to Age 95 Policy Data Pages
F5160-30; 30-Year Level Term to Age 95 Policy Data Pages
Group & NAIC #: 020-65676

Dear Mr. Musgrove:

We are submitting the required number of copies of the above-referenced forms for your review and approval. These are new forms and will not replace any forms previously approved by your Department. This product is a Term to Age 95 Life Insurance Policy with the specimen Policy Data Pages for 10, 15, 20 and 30-year level term periods.

This individually underwritten policy will be marketed through properly licensed agents in the general insurance market. The minimum face amount is \$100,000 and the face amount may not be increased or decreased after issue. However, the face amount will be contractually decreased following the end of the level term period e.g. a 10 year level term policy would have a face amount decrease in policy year 11. Cost of insurance rates are banded by face amount. The premiums as shown on the policy data pages are guaranteed at issue and are not subject to increase or decrease for in-force policies. The issue ages are: 18-75 for the 10-year; 18-65 for the 15 year; 18-60 for the 20 year; 18-50 for non-tobacco classes and 18-45 for tobacco classes for the 30 year term. The enclosed copy of the policy contains the specimen Policy Data Pages for each term as noted above. At issue, the policy will only include the Policy Data Pages for the term elected. We will use application form LFF06321, which was approved on 06/16/2008 under State Filing No. 39195.

Please accept this as our assurance that we are in compliance with the requirements of Arkansas Code Ann. 23-79-138. We provide a document entitled "Important Information to Policyholders", which contains the required information. Also, please accept this as our assurance that we are in compliance with the requirements of Regulation 49 and we provide

SERFF Tracking Number: JEPL-125878999 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 40938
Company Tracking Number: TRM5065 ET AL
TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium
Product Name: TRM5065 et al, LifeElements Level Term 2009
Project Name/Number: /TRM5065 et al, LifeElements Level Term 2009

the required Guaranty Association notice.

We have bracketed certain items in the forms as variable information because they may change for new issues in the future (but not in-force policies). These items include: officer names/signatures and the service office address, all premiums, policy fee, conversion period, modal factors and any information that varies based on the insured. It is our understanding that changes to the bracketed items for new issues will not require a new filing of these forms. We confirm that the brackets will not actually appear on the forms at issue.

When combined, the Policy and Policy Data Pages achieve a Flesch score of 55.43. This form is being submitted concurrently to our domicile state of Indiana and is pending approval. These forms will not be marketed with an illustration. The appropriate certification(s), transmittal, and filing fee are included, as applicable. To the best of our knowledge and belief, this filing complies with all the laws and regulations of your State.

We trust the information provided is satisfactory and look forward to your response. Unless submitted electronically, a postage-paid envelope has been enclosed for your convenience in corresponding with us. Should you require additional information, please feel free to contact me toll-free at 1-800-258-3648, ext. 5426, by fax at 1-603-226-5128 or via e-mail at the address shown below.

Sincerely,

James P. Kane
Analyst, Life Product Compliance
Email: James.Kane@LFG.com

Company and Contact

Filing Contact Information

James Kane, Compliance Analyst james.kane@lfg.com
One Granite Place (800) 258-3648 [Phone]
Concord, NH 03302-0515 (603) 226-5128[FAX]

Filing Company Information

SERFF Tracking Number: JEPL-125878999 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 40938
Company Tracking Number: TRM5065 ET AL
TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium
Product Name: TRM5065 et al, LifeElements Level Term 2009
Project Name/Number: /TRM5065 et al, LifeElements Level Term 2009

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
350 Church Street Group Code: 20 Company Type: Life Insurance
Hartford, CT 06103 Group Name: State ID Number:
(800) 258-3648 ext. [Phone] FEIN Number: 35-0472300

SERFF Tracking Number: JEPL-125878999 State: Arkansas

Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 40938

Company Tracking Number: TRM5065 ET AL

TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium

Product Name: TRM5065 et al, LifeElements Level Term 2009

Project Name/Number: /TRM5065 et al, LifeElements Level Term 2009

Filing Fees

Fee Required? Yes

Fee Amount: \$175.00

Retaliatory? Yes

Fee Explanation: 5 forms x \$35.00 for each form filed = \$175.00.

Retaliatory Filing Fee is greater than Arkansas' State Filing Fee.

Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|----------|----------------|---------------|
| The Lincoln National Life Insurance Company | \$175.00 | 11/21/2008 | 24089290 |

| | | | |
|--------------------------|--|------------------------|--|
| SERFF Tracking Number: | JEPL-125878999 | State: | Arkansas |
| Filing Company: | The Lincoln National Life Insurance Company | State Tracking Number: | 40938 |
| Company Tracking Number: | TRM5065 ET AL | | |
| TOI: | L04I Individual Life - Term | Sub-TOI: | L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium |
| Product Name: | TRM5065 et al, LifeElements Level Term 2009 | | |
| Project Name/Number: | /TRM5065 et al, LifeElements Level Term 2009 | | |

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|----------|------------|------------|----------------|
| Approved | Linda Bird | 11/25/2008 | 11/25/2008 |

Amendments

| Item | Schedule | Created By | Created On | Date Submitted |
|---------------------------------|---------------------|------------|------------|----------------|
| Revised Submission Letter | Supporting Document | James Kane | 11/24/2008 | 11/24/2008 |

| | | | |
|---------------------------------|---|-------------------------------|--|
| <i>SERFF Tracking Number:</i> | <i>JEPL-125878999</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>The Lincoln National Life Insurance Company</i> | <i>State Tracking Number:</i> | <i>40938</i> |
| <i>Company Tracking Number:</i> | <i>TRM5065 ET AL</i> | | |
| <i>TOI:</i> | <i>L04I Individual Life - Term</i> | <i>Sub-TOI:</i> | <i>L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium</i> |
| <i>Product Name:</i> | <i>TRM5065 et al, LifeElements Level Term 2009</i> | | |
| <i>Project Name/Number:</i> | <i>/TRM5065 et al, LifeElements Level Term 2009</i> | | |

Disposition

Disposition Date: 11/25/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

| | | | |
|--------------------------|---|------------------------|--|
| SERFF Tracking Number: | JEPL-125878999 | State: | Arkansas |
| Filing Company: | The Lincoln National Life Insurance Company | State Tracking Number: | 40938 |
| Company Tracking Number: | TRM5065 ET AL | | |
| TOI: | L04I Individual Life - Term | Sub-TOI: | L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium |

| | |
|----------------------|--|
| Product Name: | TRM5065 et al, LifeElements Level Term 2009 |
| Project Name/Number: | /TRM5065 et al, LifeElements Level Term 2009 |

| Item Type | Item Name | Item Status | Public Access |
|---------------------|---|-------------|---------------|
| Supporting Document | Certification/Notice | | Yes |
| Supporting Document | Application | | Yes |
| Supporting Document | Life & Annuity - Acturial Memo | | No |
| Supporting Document | Compliance Certification | | Yes |
| Supporting Document | Statement of Policy Cost and Benefit Information | | Yes |
| Supporting Document | Revised Submission Letter | | Yes |
| Form | Term to Age 95 Life Insurance Policy | | Yes |

SERFF Tracking Number: JEPL-125878999 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 40938
Company Tracking Number: TRM5065 ET AL
TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium
Product Name: TRM5065 et al, LifeElements Level Term 2009
Project Name/Number: /TRM5065 et al, LifeElements Level Term 2009

Amendment Letter

Amendment Date:
Submitted Date: 11/24/2008

Comments:

Revised Submission Letter referencing correct policy data page form numbers F5165-10, F5165-15, F5165-20, and F5165-30

Dear Mr. Musgrove:

Please find a revised submission letter attached below, the Filing Description of the initial SERFF submission references incorrect policy data page form numbers.

Thank You,
Jim Kane

Analyst, Life Product Compliance
The Lincoln National Life Insurance Company
1(800) 258-3648 Ext. 5426
E-mail: James.Kane@lfg.com

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Revised Submission Letter

Comment: Please find a revised submission letter attached below, the Filing Description of the initial SERFF submission references incorrect policy data page form numbers.

AR_Submission letter.pdf

SERFF Tracking Number: JEPL-125878999 State: Arkansas

Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 40938

Company Tracking Number: TRM5065 ET AL

TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium

Product Name: TRM5065 et al, LifeElements Level Term 2009

Project Name/Number: /TRM5065 et al, LifeElements Level Term 2009

Form Schedule

Lead Form Number: TRM5065

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---------------|-------------|--------------|---------------------|---------|----------------------|-------------|-----------------------|
| | TRM5065 | Policy/Cont | Term to Age 95 Life | Initial | | 55 | AR_TRM5065 Policy.pdf |
| | | ract/Fratern | Insurance Policy | | | | |
| | | al | | | | | |
| | | Certificate | | | | | |



The Lincoln National Life Insurance Company

Service Office: [100 North Greene Street, PO Box 21008, Greensboro, NC 27420-1008 (800) 487-1485]

A Stock Company

Right To Examine Your Policy – Within 20 days after You receive this policy, You may have it cancelled by returning it to Us, to the agent from whom You bought it, or to any of Our agents. The return of this policy will void it from the beginning and We will refund any premiums paid.

The Lincoln National Life Insurance Company promises to pay the Proceeds as shown on Page 4 to the beneficiary upon receipt at Our Service Office of due proof of death of the Insured, subject to the terms and conditions of this policy. All benefits will be payable subject to the policy provisions.

The First Premium Is Payable on or before delivery of this policy. Further premiums are due after the Policy Date pursuant to the provisions of this policy.

This Policy is a legal contract between the Owner ("You", "Your") and The Lincoln National Life Insurance Company ("We", "Us", "Our," and "Company"). **READ THIS POLICY CAREFULLY.**

[*Dennis R. Glass*]

[President]

[*C. Suzanne Ulmasek*]

[Secretary]

**TERM TO ATTAINED AGE 95 LIFE INSURANCE POLICY
FIXED LEVEL PREMIUMS DURING THE LEVEL TERM PERIOD
FIXED INCREASING PREMIUMS AFTER THE LEVEL TERM PERIOD
ONE-TIME FACE AMOUNT DECREASE AT
THE END OF LEVEL TERM PERIOD**

**Nonparticipating
Conversion Period Specified On Page 3
Premiums Payable To Date Of Expiry
Insurance Payable At Death Prior To Date Of Expiry**

TRM5065

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

SECTION 1 – GUIDE TO POLICY PROVISIONS

| SECTION | PROVISION | PAGE | SECTION | PROVISION | PAGE |
|----------|--|-------------|----------|--|----------|
| 2 | POLICY SPECIFICATIONS | 3, 4 | 5 | CONVERSION PRIVILEGES | 7 |
| | 2 Policy Data | | | 5.1 Regular Conversion | |
| | | | | 5.2 Other Conversions | |
| 3 | GENERAL PROVISIONS | 5 | 6 | OWNERSHIP | 7 |
| | 3.1 The Contract | | | 6.1 Rights of Ownership | |
| | 3.2 Attained Age | | | 6.2 Transfer of Ownership | |
| | 3.3 Incontestability | | | 6.3 Collateral Assignment | |
| | 3.4 Change of Provisions | | 7 | BENEFICIARIES | 8 |
| | 3.5 Misstatement of Age or Sex | | | 7.1 Designation and Change of Beneficiaries | |
| | 3.6 Payments by the Company | | | 7.2 Succession in Interest of Beneficiaries and Payees | |
| | 3.7 Suicide Exclusion | | | 7.3 Form and Effective Date | |
| | 3.8 Policy Date | | | 7.4 General | |
| | 3.9 Policy Anniversary | | 8 | SETTLEMENT OPTIONS | 8 |
| | 3.10 Policy Year | | | 8.1 Payment | |
| | 3.11 Policy Changes | | | | |
| | 3.12 Proceeds | | | | |
| | 3.13 Service Office | | | | |
| 4 | PREMIUM PAYMENT AND REINSTATEMENT | 6 | | | |
| | 4.1 Premium | | | | |
| | 4.2 Grace Period | | | | |
| | 4.3 Reinstatement | | | | |
| | 4.4 Premium Refund | | | | |
| | 4.5 Nonparticipation | | | | |

The Application and any Additional Forms will follow Page 8.

SECTION 2 – POLICY SPECIFICATIONS

| | | | |
|---------------|--------------------|---|-------------------------------------|
| POLICY NUMBER | [LNL-12345678] | | |
| INSURED | [JOHN DOE] | TERM TO ATTAINED AGE 95 LIFE INSURANCE | PLAN |
| DATE OF ISSUE | [FEBRUARY 1, 2009] | 10 YEAR | BASE POLICY LEVEL TERM PERIOD |
| AGE AT ISSUE | [35] | | |
| SEX | [MALE] | [STANDARD NON-TOBACCO] | RATE CLASS |
| | | [FEBRUARY 1, 2009] | POLICY DATE |

CONVERSION PERIOD WITHIN THE FIRST [10] POLICY YEARS AND PRIOR TO ATTAINED AGE [70]

SCHEDULE OF BENEFITS

| BENEFIT DESCRIPTION | FIRST YEAR ANNUAL PREMIUM* | DATE OF EXPIRY |
|----------------------------|-------------------------------|--------------------|
| TERM LIFE INSURANCE POLICY | \$[189.00] | [FEBRUARY 1, 2069] |

*PREMIUMS FOR ALL POLICY YEARS ARE SHOWN ON THE FOLLOWING POLICY SPECIFICATION PAGES. THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE INCLUDES A \$ [75.00] ANNUAL FEE.

PREMIUMS MAY BE PAID [ANNUALLY, SEMIANNUALLY, QUARTERLY, MONTHLY] OR AT ANY MODE AGREED UPON BY US. THE MODE OF PAYMENT MAY BE CHANGED AT ANY POLICY ANNIVERSARY BY WRITTEN AGREEMENT. THE MODAL PREMIUM WILL BE DETERMINED BY MULTIPLYING THE ANNUAL PREMIUM BY THE FOLLOWING FACTORS:

| | | | |
|------------|----------------|-------------|-----------|
| [ANNUALLY] | [SEMIANNUALLY] | [QUARTERLY] | [MONTHLY] |
| [1.000] | [.515] | [.262] | [.089] |

ANNUAL PREMIUMS AND FACE AMOUNTS SCHEDULE

POLICY NUMBER: [LNL-12345678] INSURED: [JOHN DOE]

| POLICY YEAR | *TERM LIFE INSURANCE POLICY | **TOTAL ANNUAL PREMIUMS | FACE AMOUNT |
|----------------|-----------------------------------|-------------------------------|----------------|
| [01 | [\$189.00 | [\$189.00 | [\$100,000.00 |
| 02 | 189.00 | 189.00 | 100,000.00 |
| 03 | 189.00 | 189.00 | 100,000.00 |
| 04 | 189.00 | 189.00 | 100,000.00 |
| 05 | 189.00 | 189.00 | 100,000.00 |
| 06 | 189.00 | 189.00 | 100,000.00 |
| 07 | 189.00 | 189.00 | 100,000.00 |
| 08 | 189.00 | 189.00 | 100,000.00 |
| 09 | 189.00 | 189.00 | 100,000.00 |
| 10 | 189.00 | 189.00 | 100,000.00 |
| 11 | 189.00 | 189.00 | 28,500.00 |
| 12 | 189.00 | 189.00 | 28,500.00 |
| 13 | 189.00 | 189.00 | 28,500.00 |
| 14 | 194.42 | 194.42 | 28,500.00 |
| 15 | 201.54 | 201.54 | 28,500.00 |
| 16 | 210.09 | 210.09 | 28,500.00 |
| 17 | 220.64 | 220.64 | 28,500.00 |
| 18 | 234.89 | 234.89 | 28,500.00 |
| 19 | 250.28 | 250.28 | 28,500.00 |
| 20 | 270.51 | 270.51 | 28,500.00 |
| 21 | 294.45 | 294.45 | 28,500.00 |
| 22 | 318.96 | 318.96 | 28,500.00 |
| 23 | 345.75 | 345.75 | 28,500.00 |
| 24 | 367.98 | 367.98 | 28,500.00 |
| 25 | 393.63 | 393.63 | 28,500.00 |
| 26 | 425.84 | 425.84 | 28,500.00 |
| 27 | 465.17 | 465.17 | 28,500.00 |
| 28 | 513.62 | 513.62 | 28,500.00 |
| 29 | 567.77 | 567.77 | 28,500.00 |
| 30 | 624.77 | 624.77 | 28,500.00 |
| 31 | 684.62 | 684.62 | 28,500.00 |
| 32 | 745.61 | 745.61 | 28,500.00 |
| 33 | 807.17 | 807.17 | 28,500.00 |
| 34 | 873.86 | 873.86 | 28,500.00 |
| 35 | 941.69 | 941.69 | 28,500.00 |
| 36 | 1,025.19 | 1,025.19 | 28,500.00 |
| 37] | 1,118.10] | 1,118.10] | 28,500.00] |

*THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE POLICY INCLUDES A \$ [75.00] ANNUAL FEE.

REFER TO PAGE 3 FOR INFORMATION REGARDING MODAL PREMIUM PAYMENT OPTIONS AND MODAL FACTORS.

**TOTAL ANNUAL PREMIUMS COLUMN INCLUDES PREMIUMS FOR ANY ADDITIONAL BENEFITS WHICH MAY BE ATTACHED TO YOUR POLICY. THE ANNUAL PREMIUMS SCHEDULE FOR ANY ADDITIONAL BENEFITS ARE SHOWN ON THE FOLLOWING PAGES IF APPLICABLE.

ANNUAL PREMIUMS AND FACE AMOUNTS SCHEDULE

POLICY NUMBER: [LNL-12345678] INSURED: [JOHN DOE]

| POLICY YEAR | *TERM LIFE INSURANCE POLICY | **TOTAL ANNUAL PREMIUMS | FACE AMOUNT |
|----------------|-----------------------------------|-------------------------------|----------------|
| [38 | \$[1,240.94 | \$[1,240.94 | \$(28,500.00 |
| 39 | 1,370.04 | 1,370.04 | 28,500.00 |
| 40 | 1,505.99 | 1,505.99 | 28,500.00 |
| 41 | 1,654.19 | 1,654.19 | 28,500.00 |
| 42 | 1,807.80 | 1,807.80 | 28,500.00 |
| 43 | 1,985.93 | 1,985.93 | 28,500.00 |
| 44 | 2,193.41 | 2,193.41 | 28,500.00 |
| 45 | 2,431.67 | 2,431.67 | 28,500.00 |
| 46 | 2,690.16 | 2,690.16 | 28,500.00 |
| 47 | 2,983.14 | 2,983.14 | 28,500.00 |
| 48 | 3,285.53 | 3,285.53 | 28,500.00 |
| 49 | 3,608.72 | 3,608.72 | 28,500.00 |
| 50 | 3,965.25 | 3,965.25 | 28,500.00 |
| 51 | 4,361.12 | 4,361.12 | 28,500.00 |
| 52 | 4,798.59 | 4,798.59 | 28,500.00 |
| 53 | 5,271.98 | 5,271.98 | 28,500.00 |
| 54 | 5,775.86 | 5,775.86 | 28,500.00 |
| 55 | 6,303.11 | 6,303.11 | 28,500.00 |
| 56 | 6,848.31 | 6,848.31 | 28,500.00 |
| 57 | 7,353.33 | 7,353.33 | 28,500.00 |
| 58 | 7,875.17 | 7,875.17 | 28,500.00 |
| 59 | 8,421.23 | 8,421.23 | 28,500.00 |
| 60] | 8,995.22] | 8,995.22] | 28,500.00] |

*THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE POLICY INCLUDES A \$ [75.00] ANNUAL FEE.

REFER TO PAGE 3 FOR INFORMATION REGARDING MODAL PREMIUM PAYMENT OPTIONS AND MODAL FACTORS.

**TOTAL ANNUAL PREMIUMS COLUMN INCLUDES PREMIUMS FOR ANY ADDITIONAL BENEFITS WHICH MAY BE ATTACHED TO YOUR POLICY. THE ANNUAL PREMIUMS SCHEDULE FOR ANY ADDITIONAL BENEFITS ARE SHOWN ON THE FOLLOWING PAGES IF APPLICABLE.

SECTION 2 – POLICY SPECIFICATIONS

| | | | |
|---------------|--------------------|---|-------------------------------------|
| POLICY NUMBER | [LNL-12345678] | | |
| INSURED | [JOHN DOE] | TERM TO ATTAINED AGE 95 LIFE INSURANCE | PLAN |
| DATE OF ISSUE | [FEBRUARY 1, 2009] | 15 YEAR | BASE POLICY LEVEL TERM PERIOD |
| AGE AT ISSUE | [35] | | |
| SEX | [MALE] | [STANDARD NON-TOBACCO] | RATE CLASS |
| | | [FEBRUARY 1, 2009] | POLICY DATE |

CONVERSION PERIOD WITHIN THE FIRST [15] POLICY YEARS AND PRIOR TO ATTAINED AGE [70]

SCHEDULE OF BENEFITS

| BENEFIT DESCRIPTION | FIRST YEAR ANNUAL PREMIUM* | DATE OF EXPIRY |
|----------------------------|-------------------------------|--------------------|
| TERM LIFE INSURANCE POLICY | \$[233.00] | [FEBRUARY 1, 2069] |

*PREMIUMS FOR ALL POLICY YEARS ARE SHOWN ON THE FOLLOWING POLICY SPECIFICATION PAGES. THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE INCLUDES A \$ [75.00] ANNUAL FEE.

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| | | | |
|------------|----------------|-------------|-----------|
| [ANNUALLY] | [SEMIANNUALLY] | [QUARTERLY] | [MONTHLY] |
| [1.000] | [.515] | [.262] | [.089] |

ANNUAL PREMIUMS AND FACE AMOUNTS SCHEDULE

POLICY NUMBER: [LNL-12345678] INSURED: [JOHN DOE]

| POLICY YEAR | *TERM LIFE INSURANCE POLICY | **TOTAL ANNUAL PREMIUMS | FACE AMOUNT |
|----------------|-----------------------------------|-------------------------------|----------------|
| [01 | [\$233.00 | [\$233.00 | [\$100,000.00 |
| 02 | 233.00 | 233.00 | 100,000.00 |
| 03 | 233.00 | 233.00 | 100,000.00 |
| 04 | 233.00 | 233.00 | 100,000.00 |
| 05 | 233.00 | 233.00 | 100,000.00 |
| 06 | 233.00 | 233.00 | 100,000.00 |
| 07 | 233.00 | 233.00 | 100,000.00 |
| 08 | 233.00 | 233.00 | 100,000.00 |
| 09 | 233.00 | 233.00 | 100,000.00 |
| 10 | 233.00 | 233.00 | 100,000.00 |
| 11 | 233.00 | 233.00 | 100,000.00 |
| 12 | 233.00 | 233.00 | 100,000.00 |
| 13 | 233.00 | 233.00 | 100,000.00 |
| 14 | 233.00 | 233.00 | 100,000.00 |
| 15 | 233.00 | 233.00 | 100,000.00 |
| 16 | 233.00 | 233.00 | 28,163.90 |
| 17 | 233.00 | 233.00 | 28,163.90 |
| 18 | 233.00 | 233.00 | 28,163.90 |
| 19 | 248.21 | 248.21 | 28,163.90 |
| 20 | 268.20 | 268.20 | 28,163.90 |
| 21 | 291.86 | 291.86 | 28,163.90 |
| 22 | 316.08 | 316.08 | 28,163.90 |
| 23 | 342.56 | 342.56 | 28,163.90 |
| 24 | 364.52 | 364.52 | 28,163.90 |
| 25 | 389.87 | 389.87 | 28,163.90 |
| 26 | 421.70 | 421.70 | 28,163.90 |
| 27 | 460.56 | 460.56 | 28,163.90 |
| 28 | 508.44 | 508.44 | 28,163.90 |
| 29 | 561.95 | 561.95 | 28,163.90 |
| 30 | 618.28 | 618.28 | 28,163.90 |
| 31 | 677.43 | 677.43 | 28,163.90 |
| 32 | 737.70 | 737.70 | 28,163.90 |
| 33 | 798.53 | 798.53 | 28,163.90 |
| 34 | 864.43 | 864.43 | 28,163.90 |
| 35 | 931.46 | 931.46 | 28,163.90 |
| 36 | 1,013.98 | 1,013.98 | 28,163.90 |
| 37] | 1,105.80] | 1,105.80] | 28,163.90] |

*THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE POLICY INCLUDES A \$ [75.00] ANNUAL FEE.

REFER TO PAGE 3 FOR INFORMATION REGARDING MODAL PREMIUM PAYMENT OPTIONS AND MODAL FACTORS.

**TOTAL ANNUAL PREMIUMS COLUMN INCLUDES PREMIUMS FOR ANY ADDITIONAL BENEFITS WHICH MAY BE ATTACHED TO YOUR POLICY. THE ANNUAL PREMIUMS SCHEDULE FOR ANY ADDITIONAL BENEFITS ARE SHOWN ON THE FOLLOWING PAGES IF APPLICABLE.

ANNUAL PREMIUMS AND FACE AMOUNTS SCHEDULE

POLICY NUMBER: [LNL-12345678] INSURED: [JOHN DOE]

| POLICY YEAR | *TERM LIFE INSURANCE POLICY | **TOTAL ANNUAL PREMIUMS | FACE AMOUNT |
|----------------|-----------------------------------|-------------------------------|----------------|
| [38 | \$[1,227.19 | \$[1,227.19 | \$(28,163.90 |
| 39 | 1,354.77 | 1,354.77 | 28,163.90 |
| 40 | 1,489.11 | 1,489.11 | 28,163.90 |
| 41 | 1,635.56 | 1,635.56 | 28,163.90 |
| 42 | 1,787.37 | 1,787.37 | 28,163.90 |
| 43 | 1,963.39 | 1,963.39 | 28,163.90 |
| 44 | 2,168.42 | 2,168.42 | 28,163.90 |
| 45 | 2,403.87 | 2,403.87 | 28,163.90 |
| 46 | 2,659.32 | 2,659.32 | 28,163.90 |
| 47 | 2,948.84 | 2,948.84 | 28,163.90 |
| 48 | 3,247.66 | 3,247.66 | 28,163.90 |
| 49 | 3,567.04 | 3,567.04 | 28,163.90 |
| 50 | 3,919.37 | 3,919.37 | 28,163.90 |
| 51 | 4,310.57 | 4,310.57 | 28,163.90 |
| 52 | 4,742.88 | 4,742.88 | 28,163.90 |
| 53 | 5,210.69 | 5,210.69 | 28,163.90 |
| 54 | 5,708.62 | 5,708.62 | 28,163.90 |
| 55 | 6,229.66 | 6,229.66 | 28,163.90 |
| 56 | 6,768.43 | 6,768.43 | 28,163.90 |
| 57 | 7,267.50 | 7,267.50 | 28,163.90 |
| 58 | 7,783.18 | 7,783.18 | 28,163.90 |
| 59 | 8,322.80 | 8,322.80 | 28,163.90 |
| 60] | 8,890.02] | 8,890.02] | 28,163.90] |

*THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE POLICY INCLUDES A \$ [75.00] ANNUAL FEE.

REFER TO PAGE 3 FOR INFORMATION REGARDING MODAL PREMIUM PAYMENT OPTIONS AND MODAL FACTORS.

**TOTAL ANNUAL PREMIUMS COLUMN INCLUDES PREMIUMS FOR ANY ADDITIONAL BENEFITS WHICH MAY BE ATTACHED TO YOUR POLICY. THE ANNUAL PREMIUMS SCHEDULE FOR ANY ADDITIONAL BENEFITS ARE SHOWN ON THE FOLLOWING PAGES IF APPLICABLE.

SECTION 2 – POLICY SPECIFICATIONS

| | | | |
|---------------|--------------------|---|-------------------------------------|
| POLICY NUMBER | [LNL-12345678] | | |
| INSURED | [JOHN DOE] | TERM TO ATTAINED AGE 95 LIFE INSURANCE | PLAN |
| DATE OF ISSUE | [FEBRUARY 1, 2009] | 20 YEAR | BASE POLICY LEVEL TERM PERIOD |
| AGE AT ISSUE | [35] | | |
| SEX | [MALE] | [STANDARD NON-TOBACCO] | RATE CLASS |
| | | [FEBRUARY 1, 2009] | POLICY DATE |

CONVERSION PERIOD WITHIN THE FIRST [20] POLICY YEARS AND PRIOR TO ATTAINED AGE [70]

SCHEDULE OF BENEFITS

| | | |
|----------------------------|-------------------------------|--------------------|
| BENEFIT DESCRIPTION | FIRST YEAR ANNUAL PREMIUM* | DATE OF EXPIRY |
| TERM LIFE INSURANCE POLICY | \$[250.00] | [FEBRUARY 1, 2069] |

*PREMIUMS FOR ALL POLICY YEARS ARE SHOWN ON THE FOLLOWING POLICY SPECIFICATION PAGES. THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE INCLUDES A \$ [75.00] ANNUAL FEE.

PREMIUMS MAY BE PAID [ANNUALLY, SEMIANNUALLY, QUARTERLY, MONTHLY] OR AT ANY MODE AGREED UPON BY US. THE MODE OF PAYMENT MAY BE CHANGED AT ANY POLICY ANNIVERSARY BY WRITTEN AGREEMENT. THE MODAL PREMIUM WILL BE DETERMINED BY MULTIPLYING THE ANNUAL PREMIUM BY THE FOLLOWING FACTORS:

| | | | |
|------------|----------------|-------------|-----------|
| [ANNUALLY] | [SEMIANNUALLY] | [QUARTERLY] | [MONTHLY] |
| [1.000] | [.515] | [.262] | [.089] |

ANNUAL PREMIUMS AND FACE AMOUNTS SCHEDULE

POLICY NUMBER: [LNL-12345678] INSURED: [JOHN DOE]

| POLICY YEAR | *TERM LIFE INSURANCE POLICY | **TOTAL ANNUAL PREMIUMS | FACE AMOUNT |
|----------------|-----------------------------------|-------------------------------|----------------|
| [01 | [\$[250.00 | [\$[250.00 | [\$[100,000.00 |
| 02 | 250.00 | 250.00 | 100,000.00 |
| 03 | 250.00 | 250.00 | 100,000.00 |
| 04 | 250.00 | 250.00 | 100,000.00 |
| 05 | 250.00 | 250.00 | 100,000.00 |
| 06 | 250.00 | 250.00 | 100,000.00 |
| 07 | 250.00 | 250.00 | 100,000.00 |
| 08 | 250.00 | 250.00 | 100,000.00 |
| 09 | 250.00 | 250.00 | 100,000.00 |
| 10 | 250.00 | 250.00 | 100,000.00 |
| 11 | 250.00 | 250.00 | 100,000.00 |
| 12 | 250.00 | 250.00 | 100,000.00 |
| 13 | 250.00 | 250.00 | 100,000.00 |
| 14 | 250.00 | 250.00 | 100,000.00 |
| 15 | 250.00 | 250.00 | 100,000.00 |
| 16 | 250.00 | 250.00 | 100,000.00 |
| 17 | 250.00 | 250.00 | 100,000.00 |
| 18 | 250.00 | 250.00 | 100,000.00 |
| 19 | 250.00 | 250.00 | 100,000.00 |
| 20 | 250.00 | 250.00 | 100,000.00 |
| 21 | 250.00 | 250.00 | 18,421.00 |
| 22 | 250.00 | 250.00 | 18,421.00 |
| 23 | 250.00 | 250.00 | 18,421.00 |
| 24 | 264.37 | 264.37 | 18,421.00 |
| 25 | 280.95 | 280.95 | 18,421.00 |
| 26 | 301.76 | 301.76 | 18,421.00 |
| 27 | 327.18 | 327.18 | 18,421.00 |
| 28 | 358.50 | 358.50 | 18,421.00 |
| 29 | 393.50 | 393.50 | 18,421.00 |
| 30 | 430.34 | 430.34 | 18,421.00 |
| 31 | 469.03 | 469.03 | 18,421.00 |
| 32 | 508.45 | 508.45 | 18,421.00 |
| 33 | 548.24 | 548.24 | 18,421.00 |
| 34 | 591.34 | 591.34 | 18,421.00 |
| 35 | 635.18 | 635.18 | 18,421.00 |
| 36 | 689.16 | 689.16 | 18,421.00 |
| 37] | 749.21] | 749.21] | 18,421.00] |

*THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE POLICY INCLUDES A \$ [75.00] ANNUAL FEE.

REFER TO PAGE 3 FOR INFORMATION REGARDING MODAL PREMIUM PAYMENT OPTIONS AND MODAL FACTORS.

**TOTAL ANNUAL PREMIUMS COLUMN INCLUDES PREMIUMS FOR ANY ADDITIONAL BENEFITS WHICH MAY BE ATTACHED TO YOUR POLICY. THE ANNUAL PREMIUMS SCHEDULE FOR ANY ADDITIONAL BENEFITS ARE SHOWN ON THE FOLLOWING PAGES IF APPLICABLE.

ANNUAL PREMIUMS AND FACE AMOUNTS SCHEDULE

POLICY NUMBER: [LNL-12345678] INSURED: [JOHN DOE]

| POLICY YEAR | *TERM LIFE INSURANCE POLICY | **TOTAL ANNUAL PREMIUMS | FACE AMOUNT |
|----------------|-----------------------------------|-------------------------------|----------------|
| [38 | [\$828.60 | [\$828.60 | [\$18,421.00 |
| 39 | 912.05 | 912.05 | 18,421.00 |
| 40 | 999.92 | 999.92 | 18,421.00 |
| 41 | 1,095.71 | 1,095.71 | 18,421.00 |
| 42 | 1,195.00 | 1,195.00 | 18,421.00 |
| 43 | 1,310.13 | 1,310.13 | 18,421.00 |
| 44 | 1,444.23 | 1,444.23 | 18,421.00 |
| 45 | 1,598.23 | 1,598.23 | 18,421.00 |
| 46 | 1,765.31 | 1,765.31 | 18,421.00 |
| 47 | 1,954.68 | 1,954.68 | 18,421.00 |
| 48 | 2,150.13 | 2,150.13 | 18,421.00 |
| 49 | 2,359.02 | 2,359.02 | 18,421.00 |
| 50 | 2,589.47 | 2,589.47 | 18,421.00 |
| 51 | 2,845.33 | 2,845.33 | 18,421.00 |
| 52 | 3,128.10 | 3,128.10 | 18,421.00 |
| 53 | 3,434.07 | 3,434.07 | 18,421.00 |
| 54 | 3,759.75 | 3,759.75 | 18,421.00 |
| 55 | 4,100.54 | 4,100.54 | 18,421.00 |
| 56 | 4,452.93 | 4,452.93 | 18,421.00 |
| 57 | 4,779.35 | 4,779.35 | 18,421.00 |
| 58 | 5,116.64 | 5,116.64 | 18,421.00 |
| 59 | 5,469.59 | 5,469.59 | 18,421.00 |
| 60] | 5,840.59] | 5,840.59] | 18,421.00] |

*THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE POLICY INCLUDES A \$ [75.00] ANNUAL FEE.

REFER TO PAGE 3 FOR INFORMATION REGARDING MODAL PREMIUM PAYMENT OPTIONS AND MODAL FACTORS.

**TOTAL ANNUAL PREMIUMS COLUMN INCLUDES PREMIUMS FOR ANY ADDITIONAL BENEFITS WHICH MAY BE ATTACHED TO YOUR POLICY. THE ANNUAL PREMIUMS SCHEDULE FOR ANY ADDITIONAL BENEFITS ARE SHOWN ON THE FOLLOWING PAGES IF APPLICABLE.

SECTION 2 – POLICY SPECIFICATIONS

| | | | |
|---------------|--------------------|---|-------------------------------------|
| POLICY NUMBER | [LNL-12345678] | | |
| INSURED | [JOHN DOE] | TERM TO ATTAINED AGE 95 LIFE INSURANCE | PLAN |
| DATE OF ISSUE | [FEBRUARY 1, 2009] | 30 YEAR | BASE POLICY LEVEL TERM PERIOD |
| AGE AT ISSUE | [35] | | |
| SEX | [MALE] | [STANDARD NON-TOBACCO] | RATE CLASS |
| | | [FEBRUARY 1, 2009] | POLICY DATE |

CONVERSION PERIOD WITHIN THE FIRST [30] POLICY YEARS AND PRIOR TO ATTAINED AGE [70]

SCHEDULE OF BENEFITS

| BENEFIT DESCRIPTION | FIRST YEAR ANNUAL PREMIUM* | DATE OF EXPIRY |
|----------------------------|-------------------------------|--------------------|
| TERM LIFE INSURANCE POLICY | \$[412.00] | [FEBRUARY 1, 2069] |

*PREMIUMS FOR ALL POLICY YEARS ARE SHOWN ON THE FOLLOWING POLICY SPECIFICATION PAGES. THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE INCLUDES A \$ [75.00] ANNUAL FEE.

PREMIUMS MAY BE PAID [ANNUALLY, SEMIANNUALLY, QUARTERLY, MONTHLY] OR AT ANY MODE AGREED UPON BY US. THE MODE OF PAYMENT MAY BE CHANGED AT ANY POLICY ANNIVERSARY BY WRITTEN AGREEMENT. THE MODAL PREMIUM WILL BE DETERMINED BY MULTIPLYING THE ANNUAL PREMIUM BY THE FOLLOWING FACTORS:

| | | | |
|------------|----------------|-------------|-----------|
| [ANNUALLY] | [SEMIANNUALLY] | [QUARTERLY] | [MONTHLY] |
| [1.000] | [.515] | [.262] | [.089] |

ANNUAL PREMIUMS AND FACE AMOUNTS SCHEDULE

POLICY NUMBER: [LNL-12345678] INSURED: [JOHN DOE]

| POLICY YEAR | *TERM LIFE INSURANCE POLICY | **TOTAL ANNUAL PREMIUMS | FACE AMOUNT |
|----------------|-----------------------------------|-------------------------------|----------------|
| [01 | [\$[412.00 | [\$[412.00 | [\$[100,000.00 |
| 02 | 412.00 | 412.00 | 100,000.00 |
| 03 | 412.00 | 412.00 | 100,000.00 |
| 04 | 412.00 | 412.00 | 100,000.00 |
| 05 | 412.00 | 412.00 | 100,000.00 |
| 06 | 412.00 | 412.00 | 100,000.00 |
| 07 | 412.00 | 412.00 | 100,000.00 |
| 08 | 412.00 | 412.00 | 100,000.00 |
| 09 | 412.00 | 412.00 | 100,000.00 |
| 10 | 412.00 | 412.00 | 100,000.00 |
| 11 | 412.00 | 412.00 | 100,000.00 |
| 12 | 412.00 | 412.00 | 100,000.00 |
| 13 | 412.00 | 412.00 | 100,000.00 |
| 14 | 412.00 | 412.00 | 100,000.00 |
| 15 | 412.00 | 412.00 | 100,000.00 |
| 16 | 412.00 | 412.00 | 100,000.00 |
| 17 | 412.00 | 412.00 | 100,000.00 |
| 18 | 412.00 | 412.00 | 100,000.00 |
| 19 | 412.00 | 412.00 | 100,000.00 |
| 20 | 412.00 | 412.00 | 100,000.00 |
| 21 | 412.00 | 412.00 | 100,000.00 |
| 22 | 412.00 | 412.00 | 100,000.00 |
| 23 | 412.00 | 412.00 | 100,000.00 |
| 24 | 412.00 | 412.00 | 100,000.00 |
| 25 | 412.00 | 412.00 | 100,000.00 |
| 26 | 412.00 | 412.00 | 100,000.00 |
| 27 | 412.00 | 412.00 | 100,000.00 |
| 28 | 412.00 | 412.00 | 100,000.00 |
| 29 | 412.00 | 412.00 | 100,000.00 |
| 30 | 412.00 | 412.00 | 100,000.00 |
| 31 | 412.00 | 412.00 | 10,930.90 |
| 32 | 412.00 | 412.00 | 10,930.90 |
| 33 | 412.00 | 412.00 | 10,930.90 |
| 34 | 442.61 | 442.61 | 10,930.90 |
| 35 | 473.98 | 473.98 | 10,930.90 |
| 36 | 512.35 | 512.35 | 10,930.90 |
| 37] | 555.09] | 555.09] | 10,930.90] |

*THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE POLICY INCLUDES A \$ [75.00] ANNUAL FEE.

REFER TO PAGE 3 FOR INFORMATION REGARDING MODAL PREMIUM PAYMENT OPTIONS AND MODAL FACTORS.

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ANNUAL PREMIUMS AND FACE AMOUNTS SCHEDULE

POLICY NUMBER: [LNL-12345678] INSURED: [JOHN DOE]

| POLICY YEAR | *TERM LIFE INSURANCE POLICY | **TOTAL ANNUAL PREMIUMS | FACE AMOUNT |
|----------------|-----------------------------------|-------------------------------|----------------|
| [38 | [\$611.71 | [\$611.71 | [\$10,930.90 |
| 39 | 671.06 | 671.06 | 10,930.90 |
| 40 | 733.70 | 733.70 | 10,930.90 |
| 41 | 801.90 | 801.90 | 10,930.90 |
| 42 | 872.52 | 872.52 | 10,930.90 |
| 43 | 954.50 | 954.50 | 10,930.90 |
| 44 | 1,049.93 | 1,049.93 | 10,930.90 |
| 45 | 1,159.67 | 1,159.67 | 10,930.90 |
| 46 | 1,278.71 | 1,278.71 | 10,930.90 |
| 47 | 1,413.49 | 1,413.49 | 10,930.90 |
| 48 | 1,552.64 | 1,552.64 | 10,930.90 |
| 49 | 1,701.41 | 1,701.41 | 10,930.90 |
| 50 | 1,865.48 | 1,865.48 | 10,930.90 |
| 51 | 2,047.70 | 2,047.70 | 10,930.90 |
| 52 | 2,249.05 | 2,249.05 | 10,930.90 |
| 53 | 2,466.90 | 2,466.90 | 10,930.90 |
| 54 | 2,698.74 | 2,698.74 | 10,930.90 |
| 55 | 2,941.41 | 2,941.41 | 10,930.90 |
| 56 | 3,192.49 | 3,192.49 | 10,930.90 |
| 57 | 3,424.77 | 3,424.77 | 10,930.90 |
| 58 | 3,665.04 | 3,665.04 | 10,930.90 |
| 59 | 3,916.34 | 3,916.34 | 10,930.90 |
| 60] | 4,180.54] | 4,180.54] | 10,930.90] |

*THE ANNUAL PREMIUM FOR THE TERM LIFE INSURANCE POLICY INCLUDES A \$ [75.00] ANNUAL FEE.

REFER TO PAGE 3 FOR INFORMATION REGARDING MODAL PREMIUM PAYMENT OPTIONS AND MODAL FACTORS.

**TOTAL ANNUAL PREMIUMS COLUMN INCLUDES PREMIUMS FOR ANY ADDITIONAL BENEFITS WHICH MAY BE ATTACHED TO YOUR POLICY. THE ANNUAL PREMIUMS SCHEDULE FOR ANY ADDITIONAL BENEFITS ARE SHOWN ON THE FOLLOWING PAGES IF APPLICABLE.

SECTION 3 – GENERAL PROVISIONS

3.1 The Contract

This is Your policy. This policy, the attached copy of the application and/or endorsements, and any attached supplemental applications and riders form the entire contract. All statements made by or for the Insured are, in the absence of fraud, considered to be representations and not warranties. We will not use any statement by or for the Insured to void this policy or to deny a claim unless it is contained in an application.

3.2 Attained Age

The Insured's Age At Issue, as shown in Section 2, plus the number of completed Policy Years.

3.3 Incontestability

In the absence of fraud, We will not contest this policy after it has been in force during the Insured's lifetime for two (2) years from the Date of Issue. If this policy is reinstated, the incontestability period will start over again beginning on the reinstatement date, but only for statements made in the application for reinstatement.

3.4 Change of Provisions

Only one of Our authorized officers can change the terms or waive provisions of this policy. Any such change must be in writing.

3.5 Misstatement of Age or Sex

If the Insured's age or sex is misstated, We will adjust any Proceeds payable to the amount which the premiums paid would have purchased at the correct age and sex according to Our rates on the Policy Date.

3.6 Payments by the Company

All payments by Us under this policy are payable in United States currency.

3.7 Suicide Exclusion

If this policy is in force and the Insured commits suicide, while sane or insane, within two (2) years from the Date of Issue, We will limit Our payment to a refund of premiums paid.

3.8 Policy Date

The date We use to determine Policy Anniversaries, Policy Years and policy months. If a requested Policy Date should fall on the 29th, 30th, or 31st of a month, the Policy Date will be the 28th of such month.

3.9 Policy Anniversary

The same date as the Policy Date for each succeeding year this policy remains in force.

3.10 Policy Year

A one year period of time starting on successive Policy Anniversaries, with the first Policy Year starting on the Policy Date.

3.11 Policy Changes

With the exception of the one-time face amount decrease as shown in Section 2 and any adjustment as required under Section 3.5, no increases or decreases in the face amount of this policy will be permitted.

3.12 Proceeds

The money We will pay as a death benefit, shown as the applicable face amount on Page 4; less any overdue premium(s); plus any premium refund.

3.13 Service Office

Our principal place of business as shown on Page 1.

SECTION 4 – PREMIUM PAYMENT AND REINSTATEMENT

4.1 Premium

All premiums after the first are payable at Our Service Office or to one of Our agents. All premiums are payable in United States currency. A premium must be paid on or before its due date. We will provide a premium receipt upon request if required by the laws of the state in which this policy is delivered. The annual premiums for this policy are shown in Section 2. Premiums may be paid annually, semiannually, quarterly, monthly (based on Our published modal factors as shown in Section 2) or at any mode agreed upon by Us. The mode of payment may be changed at any Policy Anniversary by written agreement.

4.2 Grace Period

A 31 day grace period will be allowed for payment of any premium after the first. The policy will remain in force during this period. If the Insured dies within the grace period, any overdue premium will be paid from the Proceeds of the policy. If the premium is not paid within the grace period, the policy will lapse as of the due date.

4.3 Reinstatement

This policy lapses at the end of the grace period. It may be reinstated during the lifetime of the Insured and within five (5) years after the due date of the unpaid premium. Within fifteen (15) days after the end of the grace period and during the lifetime of the Insured, the policy may be reinstated by payment of the overdue premium. After fifteen (15) days after the end of the grace period, reinstatement is subject to:

- a) Evidence of insurability satisfactory to Us; and
- b) Payment of all overdue premiums; and
- c) Interest on all overdue premiums from the due date of each premium. The interest rate is six percent (6%) per annum, compounded annually.

Limitations may apply to the reinstatement of additional riders and/or benefits that may be attached, as stipulated in the provisions of additional riders and/or benefits.

4.4 Premium Refund

We will refund, as part of the Proceeds, the portion of the premium paid for a period beyond the policy month in which the Insured dies. There shall be no other premium refund except as required by law.

4.5 Nonparticipation

This policy does not share in Our earnings. No dividends are payable.

SECTION 5 – CONVERSION PRIVILEGES

5.1 Regular Conversion

You may convert this policy during the conversion period described in Section 2 on Page 3, if no premium is in default. No proof of insurability is required to convert the base policy. You may change to any permanent life plan made available by Us for the purpose of conversion on the date of conversion. The amount of insurance on the new permanent policy may not be increased. The same underwriting and/or rate class may not be available under the new policy on the date of conversion. In such case, We will determine an appropriate and reasonably equivalent rate class for the Insured based on the rate class structure applicable to Your new policy and using underwriting criteria consistent with those used when this policy was issued. Otherwise, Your new policy will be issued with the same rate class as this policy, along with any indicated substandard or flat extra rating. The new policy will be subject to any assignment of this policy.

5.2 Other Conversions

Proof of insurability and Our consent will be required if the new policy:

- a) Involves insurance on another life; or
- b) Includes an increase in the amount of insurance; or
- c) Includes any rider even if it was on this policy, unless the rider's terms provide that it will continue on any conversion policy.

SECTION 6 – OWNERSHIP

6.1 Rights of Ownership

This policy belongs to You. The Owner ("You", "Your") is the Insured unless otherwise stated in the application or unless changed under the Transfer of Ownership provision. All rights granted by this policy may be exercised by You only during the Insured's lifetime and thereafter to the extent permitted by Sections 7 and 8. All rights may be exercised by You without the consent of any revocable beneficiary. These rights, however, are subject to the written consent of any irrevocable beneficiary.

6.2 Transfer of Ownership

You may transfer the Ownership of this policy on forms provided by Us. The written evidence of transfer must be recorded by Us at Our Service Office. The transfer will then be effective as of the date it is signed. We may require the return of the policy for endorsement. The transfer is subject to any payment made or other action taken by Us before We received Your written request. You may also name a Contingent Owner in the same manner. The Contingent Owner will become the Owner if the named Contingent Owner is living and You are still the Owner at the time of Your death.

6.3 Collateral Assignment

You may also assign this policy as collateral security. We assume no responsibility for the validity or effect of any collateral assignment of this policy. The assignment is subject to any payment or action taken by Us before We received the assignment at Our Service Office. The interest of any beneficiary will be subject to any collateral assignment made either before or after the beneficiary designation. A collateral assignee is not an Owner. A collateral assignment is not a transfer of ownership. Ownership can be transferred only as set forth in Section 6.2.

SECTION 7 – BENEFICIARIES

7.1 Designation and Change of Beneficiaries

The beneficiary is the person or persons named to receive the Proceeds of this policy upon the death of the Insured. The designation of beneficiary in the application shall remain in effect until You change it. You may designate and change the primary and contingent beneficiaries and further payees of Proceeds. You may do this during the lifetime of the Insured. Any beneficiary that You designate as irrevocable must provide written consent for You to exercise any right specified in this policy.

7.2 Succession in Interest of Beneficiaries and Payees

Unless otherwise provided, the following will apply:

- a) The beneficiary at the Insured's death will be as stated in the designation then in effect;
- b) The Proceeds will be payable in equal shares to the primary beneficiaries who survive the Insured;
- c) The unpaid shares of any primary payee who dies while receiving payments will be payable in equal shares to the other primary payees who survive the Insured;
- d) At the death of the last surviving primary beneficiary, the Proceeds will be payable in equal shares to the contingent beneficiaries who survive the Insured.
- e) The unpaid share of any contingent payee who dies while receiving payments will be payable in equal shares to the other contingent payees who survive.
- f) If there are no surviving beneficiaries, then the Proceeds shall be paid to You or to Your estate.

7.3 Form and Effective Date

Any change You make must be in writing and in a form satisfactory to Us. Such change will become effective when it is recorded by Us at Our Service Office. Upon such recording, it will then relate back to the date You signed the change, whether or not the Insured was living on the date of recording. Any change is subject to the rights of any assignee of record with Us. Any change is subject to any action or payment made by Us before recording.

7.4 General

A transfer of ownership will not of itself change the interest of any payee. So far as permitted by law, no amount payable under this policy will be subject to the claims of creditors of any payee. A payee succeeding to an interest under a settlement option will continue to be paid under the terms of that option. The rights of a beneficiary under this policy are subordinate to the rights of any person to whom the policy has been assigned.

SECTION 8 – SETTLEMENT OPTIONS

8.1 Payment

When the Insured dies while the policy is in force, Proceeds may be paid in a lump sum or left with Us for payment under a settlement option that We make available. The Proceeds will include any premium refund payable.

When this policy becomes a claim due to the death of the Insured, settlement will be made within 30 days after receipt of due proof of death. If the Proceeds are not paid within thirty (30) days, We shall pay interest on the Proceeds from the date of death of the Insured to the date when Proceeds are paid. Interest shall be paid at the rate described in Ark. Code Ann. 23-81-118.

A settlement option may be elected only if the amount of the Proceeds is \$2,000 or more. We may change the interval of payments to three (3), six (6), or twelve (12) months, if necessary to increase the payments under the settlement option to at least \$20.00 each.

You may make, change or revoke an election at any time while the Insured is alive. Following the death of the Insured, the beneficiary may elect an option if You have not elected one or if Proceeds are payable in one sum. A beneficiary may make a change in payment under a settlement option You elect only if You provided for it in Your election.

A change of beneficiary automatically cancels a previous election of a settlement option.

If this policy is assigned, the assignee's portion of Proceeds will be paid in one sum. Any balance or Proceeds may be applied under a settlement option.

To the extent allowed by law, all payments under the policy will be free from creditor claims or legal process.

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THE LINCOLN NATIONAL LIFE INSURANCE COMPANY
HOME OFFICE: Fort Wayne, Indiana

**TERM TO ATTAINED AGE 95 LIFE INSURANCE POLICY
FIXED LEVEL PREMIUMS DURING THE LEVEL TERM PERIOD
FIXED INCREASING PREMIUMS AFTER THE LEVEL TERM PERIOD
ONE-TIME FACE AMOUNT DECREASE AT
THE END OF LEVEL TERM PERIOD**

**Nonparticipating
Conversion Period Specified On Page 3
Premiums Payable To Date Of Expiry
Insurance Payable At Death Prior To Date Of Expiry**

For Service or Information about Your policy or to file a claim, contact Your Lincoln National Life Insurance Company Agent or call Our Service Office at 800-487-1485.

| | | | |
|---------------------------------|---|-------------------------------|--|
| <i>SERFF Tracking Number:</i> | <i>JEPL-125878999</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>The Lincoln National Life Insurance Company</i> | <i>State Tracking Number:</i> | <i>40938</i> |
| <i>Company Tracking Number:</i> | <i>TRM5065 ET AL</i> | | |
| <i>TOI:</i> | <i>L04I Individual Life - Term</i> | <i>Sub-TOI:</i> | <i>L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium</i> |
| <i>Product Name:</i> | <i>TRM5065 et al, LifeElements Level Term 2009</i> | | |
| <i>Project Name/Number:</i> | <i>/TRM5065 et al, LifeElements Level Term 2009</i> | | |

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: JEPL-125878999 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 40938
Company Tracking Number: TRM5065 ET AL
TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium
Product Name: TRM5065 et al, LifeElements Level Term 2009
Project Name/Number: /TRM5065 et al, LifeElements Level Term 2009

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/29/2008

Comments:

Please see Rule and Regulation 19 Certification and Readability/Flesch Certification attached below. Also, please see Certification regarding Rates.

Attachments:

AR_Regulation 19 Certification_Term.pdf
AR_Readability.pdf
AR_Consent Cert for Rate_Term.pdf

Review Status:

Satisfied -Name: Application 10/29/2008

Comments:

Please see application LFF06321 approved on 06/16/2008 under State Filing No. 39195.

Attachment:

LFF06321_Generic Fillable.pdf

Review Status:

Satisfied -Name: Compliance Certification 11/21/2008

Comments:

Please see Certification of Compliance attached below.

Attachment:

AR_Cert of Compliance_Term.pdf

Review Status:

Satisfied -Name: Statement of Policy Cost and
Benefit Information 11/21/2008

Comments:

Please see sample 15 Yr. Statement of Policy Cost and Benefit Information document attached below.

Attachment:

Lincoln LifeElements Term 2009_State of Policy Cost Base Policy 15 YR.pdf

SERFF Tracking Number: JEPL-125878999 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 40938
Company Tracking Number: TRM5065 ET AL
TOI: L04I Individual Life - Term Sub-TOI: L04I.313 Decreasing - Single Life -
Fixed/Indeterminate Premium
Product Name: TRM5065 et al, LifeElements Level Term 2009
Project Name/Number: /TRM5065 et al, LifeElements Level Term 2009

Review Status:

Satisfied -Name: Revised Submission Letter 11/24/2008

Comments:

Please find a revised submission letter attached below, the Filing Description of the initial SERFF submission references incorrect policy data page form numbers.

Attachment:

AR_Submission letter.pdf

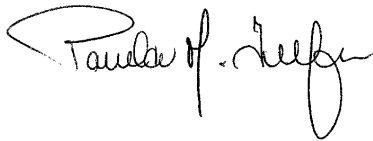
ARKANSAS

CERTIFICATION OF COMPLIANCE

The Lincoln National Life Insurance Company

RE: **TRM5065 – Individual Term to Age 95 Life Insurance Policy
with Policy Data Pages F5165-10, F5165-15, F5165-20 & F5165-30**

To the best of my knowledge and belief, the policy form listed above complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.



Pamela Telfer
Assistant Vice President
Product Compliance

Date: November 10, 2008

Arkansas

READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

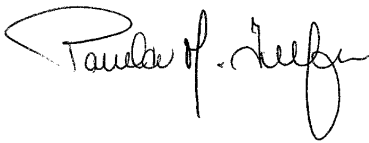
Re: TRM5065 – Individual term to Age 95 Life Insurance Policy with Policy Data Pages
F5165-10, F5165-15, F5165-20 and F5165-30

We hereby certify that the attached Form(s) is (are) in compliance with the Rules and Regulation requirements regarding Life, Annuities, and Accident and Sickness Insurance Language Simplification Standards and has (have) achieved a Flesch Reading Ease score of:

Form Number:

Flesch:

TRM5065 with any of the policy data pages listed above 55.43



Pamela M. Telfer, Assistant Vice President
Product Compliance

Date: November 10, 2008

ARKANSAS

CONSENT TO SUBMIT RATES AND/OR COST BASES FOR APPROVAL

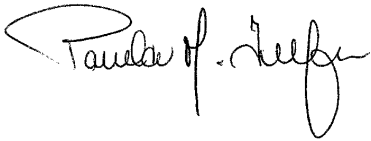
The Lincoln National Life Insurance Company

The Lincoln National Life Insurance Company, of *Fort Wayne, Indiana* does hereby consent and agree:

- A) That all premium rates and/or cost bases both “maximum” and “current or projected” used in relation to policy form number *TRM5065 with F5165-10, F5165-15, F5165-20 & F5165-30* must be filed with the Insurance Commissioner for the State of Arkansas (“Commissioner”) at least sixty (60) days prior to their proposed effective date. Such rates and/or cost bases shall be deemed effective sixty (60) days after they are filed with the Commissioner, unless the Commissioner shall approve or disapprove such rates and/or cost bases prior to the expiration of sixty (60) days.

or

- B) that where this policy is a flexible or indeterminate premium life policy which provides for frequent changes in interest rates based on financial market conditions, the company may file a range of rates it will stay within and will notify the Department at least sixty (60) days prior to any change in the range of rates. The company must also document the method used to calculate its premium and range of rates.



By:

Pamela M. Telfer, AVP
Product Compliance

Date: November 10, 2008

APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED A (Required Section)

| | | |
|---|---|--|
| 1. Proposed Insured A (First, Middle, Last) | | 2. <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 3. Date of Birth (If over age 70, please complete Section D.) (mm/dd/yy) | 4. Soc. Sec. No. | 5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country? |
| 6. Place of Birth (State, Country) | 7. Driver's License # & State | |
| 8. Home Address (Street, City, State, ZIP) | | |
| 9. Occupation/Duties | 10. Employer | |
| 11. Business Address (Street, City, State, ZIP) | | |
| 12. Annual Earned Income \$ | 13. Annual Unearned Income \$ | 14. Net Worth \$ |
| 15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N (If "Yes," please complete the Financial Supplement.) | 16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM | 17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM |

COVERAGE INFORMATION (As available per product)

18. Plan of Insurance _____ 19. Amount of Insurance \$ _____
(Specified Amount, if UL or VUL)

20. (i) Death Benefit Option (Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)
☐ Level ☐ Increase by Cash Value ☐ Increase by Premium ☐ Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
☐ Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

21. Save Age? ☐ Y ☐ N (If not saving age, policy will be current dated.)

| | |
|--|---|
| 22. Additional Benefits and Riders: (If applicable) | <input type="checkbox"/> Waiver of Premium |
| <input type="checkbox"/> Supplemental Coverage \$ _____ | <input type="checkbox"/> Waiver of Monthly Deductions |
| <input type="checkbox"/> Term on Spouse/Other Insured Rider \$ _____ (Please complete Section B - Applicant Information - Proposed Insured B) | <input type="checkbox"/> Waiver of Specified Premium \$ _____ |
| <input type="checkbox"/> Accelerated Benefit Rider | <input type="checkbox"/> Children's Term Insurance Rider (Complete Child's Supplement) |
| <input type="checkbox"/> Other Benefits and Riders (not listed above). (Please provide full details: e.g. coverage amounts/percentages/etc.): | |

BILLING INSTRUCTIONS (As available per product)

23. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT) ☐ Other _____

24. Modal Planned Premium: \$ _____ 25. Lump Sum: \$ _____ ☐ 1035 Exchange

26. Special Billing: (check one, if applicable) ☐ New List Bill ☐ Existing List Bill Number: _____

27. Source of Premium: _____ (inheritance, loan, business activity) 28. Automatic Premium Loan: ☐ Y ☐ N
(Complete for Whole Life only.)

29. Premium Notices To: (check one only.) (Please note we cannot bill to your agent.)
☐ Owner in Question 31 ☐ Owner in Question 37 ☐ Insured at Business ☐ Insured at Residence ☐ Other (indicate below)

30. Special Instructions:

OWNER INFORMATION *(If left blank, Proposed Insured(s) will be owner)*

31. Owner Name

32. Owner Address

33. Relationship to
Proposed Insured(s)

34. Owner Soc. Sec. No. / TIN

35. Date of Birth/Trust Date

36. Citizen of (Country)

37. Owner Name

38. Owner Address

39. Relationship to
Proposed Insured(s)

40. Owner Soc. Sec. No. / TIN

41. Date of Birth/Trust Date

42. Citizen of (Country)

43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? ☐ Y ☐ N**BENEFICIARY DESIGNATION** *(Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)*Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here ☐.

| | | |
|---|-------------------------------|-------------------------------------|
| 44. <input type="checkbox"/> P <input type="checkbox"/> C | a. Name/Trust name & Trustees | b. Soc. Sec. No./TIN |
| | | c. Relationship to Proposed Insured |
| 45. <input type="checkbox"/> P <input type="checkbox"/> C | a. Name/Trust name & Trustees | b. Soc. Sec. No./TIN |
| | | c. Relationship to Proposed Insured |
| 46. <input type="checkbox"/> P <input type="checkbox"/> C | a. Name/Trust name & Trustees | b. Soc. Sec. No./TIN |
| | | c. Relationship to Proposed Insured |
| 47. <input type="checkbox"/> P <input type="checkbox"/> C | a. Name/Trust name & Trustees | b. Soc. Sec. No./TIN |
| | | c. Relationship to Proposed Insured |
| 48. | Special Instructions | |

APPLICANT INFORMATION - PROPOSED INSURED A49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Y ☐ N
*(If "Yes", please complete and sign all required replacement forms.)*50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)***If none, check this box:** ☐

Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).

| Company | Face Amount | Policy Number | Issue Date (mm/dd/yy) | Replacement or Change of Policy? | 1035 Exchange | Type |
|---------|-------------|---------------|-----------------------|---|---|------|
| | \$ | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | \$ | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | \$ | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | \$ | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | |

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? (If "Yes," please provide details in the space provided.)

☐ Y ☐ N

| Company | Amount | Type (Life or Disability) | Reason Policy Applied For |
|---------|--------|---------------------------|---------------------------|
| | \$ | | |
| | \$ | | |

52. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes," please complete the Premium Financing Supplement.)

☐ Y ☐ N

54. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If "Yes," provide further information in the "Details" space provided.)

☐ Y ☐ N

GENERAL RISK INFORMATION - PROPOSED INSURED A

55. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes," an Aviation Supplement is required; this includes balloon pilots.)

☐ Y ☐ N

56. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? (If "Yes," an Avocation Supplement is required.)

☐ Y ☐ N

57. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? (If "Yes," a Foreign Travel or Residence Supplement is required.)

☐ Y ☐ N

58. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? (If "Yes," please indicate what type and dates in the "Details" space provided.)

☐ Y ☐ N

59. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes," please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.)

☐ Y ☐ N

60. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? (If "Yes," please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)

☐ Y ☐ N

61. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes," list below.)

☐ Y ☐ N

Type: Date First Used: Date Last Used: Amount and Frequency:

| | | | |
|--|--|--|--|
| | | | |
| | | | |
| | | | |

MEDICAL INFORMATION - PROPOSED INSURED A (Answer this section only when required.)

62. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

63. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Y ☐ N
Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

| 64. | Age if Living & Health Status | Diabetes, Cancer, Heart Disease? (include age of onset) | Age at Death & Cause |
|---------------|-------------------------------|--|----------------------|
| a. Father | | | |
| b. Mother | | | |
| c. Sibling(s) | | | |

65. **Details:** (List details from questions answered "Yes" and please specify to which question numbers details pertain.)

SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process.
See Underwriting Guidelines for further details.)

| 1. Proposed Insured A (First, Middle, Last) | 2. Date of Birth (mm/dd/yy) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--------------------------|-----|----|---|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--|--|--|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--|--|---|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--|--|---|--|--|
| <p>► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>5. Have you ever had any indication of, or been treated by a licensed medical professional for:</td> <td></td> <td></td> </tr> <tr> <td>a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. Anemia, leukemia, clotting disorder or any other blood disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>k. Any disorder of the eyes, ears, nose or throat?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>l. Any mental or physical disorder medically or surgically treated condition not listed above?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>7. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Type _____ Frequency _____ Amount _____</td> <td></td> <td></td> </tr> <tr> <td>8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="3">10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.</td> </tr> <tr> <td colspan="3">11. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)</td> </tr> </tbody></table> | | Yes | No | 3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you ever had any indication of, or been treated by a licensed medical professional for: | | | a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> | b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes? | <input type="checkbox"/> | <input type="checkbox"/> | c. Anemia, leukemia, clotting disorder or any other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder? | <input type="checkbox"/> | <input type="checkbox"/> | e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> | f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> | g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> | h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> | i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder? | <input type="checkbox"/> | <input type="checkbox"/> | j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin? | <input type="checkbox"/> | <input type="checkbox"/> | k. Any disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | l. Any mental or physical disorder medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.) | <input type="checkbox"/> | <input type="checkbox"/> | Type _____ Frequency _____ Amount _____ | | | 8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not? | <input type="checkbox"/> | <input type="checkbox"/> | 9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics? | <input type="checkbox"/> | <input type="checkbox"/> | 10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements. | | | 11. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.) | | |
| | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. Have you ever had any indication of, or been treated by a licensed medical professional for: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Anemia, leukemia, clotting disorder or any other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| k. Any disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| l. Any mental or physical disorder medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type _____ Frequency _____ Amount _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPOSED INSURED B

| | | | |
|---|---|--|--|
| 1. Proposed Insured B (First, Middle, Last) | | 2. <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| 3. Date of Birth (If over age 70 please complete Section D.) (mm/dd/yy) | 4. Soc. Sec. No. | 5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country? | |
| 6. Place of Birth (State, Country) | 7. Driver's License # & State | | |
| 8. Home Address (Street, City, State, ZIP) | | | |
| 9. Occupation/Duties | | 10. Employer | |
| 11. Business Address (Street, City, State, ZIP) | | | |
| 12. Annual Earned Income \$ | 13. Annual Unearned Income \$ | 14. Net Worth \$ | |
| 15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N (If "Yes," please complete the Financial Supplement.) | 16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM | 17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM | |

| | | |
|---|---------------------------------------|--|
| 18. Beneficiary for applicable Rider: a. Name | | |
| b. Soc Sec. No./TIN | c. Relationship to Proposed Insured B | |

19. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Y ☐ N
(If "Yes," please complete and sign all required replacement forms.)

20. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. (Please list in the box below.)

If none, check this box: ☐

Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).

| Company | Face Amount | Policy Number | Issue Date (mm/dd/yy) | Replacement or Change of Policy? | 1035 Exchange | Type |
|---------|-------------|---------------|-----------------------|---|---|------|
| | \$ | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | \$ | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | \$ | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | |
| | \$ | | | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | |

21. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? (If "Yes," please provide details in the space provided.) ☐ Y ☐ N

| Company | Amount | Type (Life or Disability) | Reason Policy Applied For |
|---------|--------|---------------------------|---------------------------|
| | \$ | | |
| | \$ | | |

22. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? \$ _____

23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes," please complete the Premium Financing Supplement.) ☐ Y ☐ N

24. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If "Yes," provide further information in the "Details" space provided.) ☐ Y ☐ N

GENERAL RISK INFORMATION - PROPOSED INSURED B

- | | |
|--|---|
| 25. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes", an Aviation Supplement is required; this includes balloon pilots.) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 26. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? (If "Yes", an Avocation Supplement is required.) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 27. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? (If "Yes", a Foreign Travel or Residence Supplement is required.) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 28. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? (If "Yes," please indicate what type and dates in space provided below.) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 29. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 30. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? (If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; on the space provided below.) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 31. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes", list below.) | <input type="checkbox"/> Y <input type="checkbox"/> N |

| | | | |
|--|--|--|--|
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MEDICAL INFORMATION - PROPOSED INSURED B *(Answer this section only when required.)*

- | | |
|--|--|
| 32. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years. | |
| a. Date and reason of last visit: | |
| b. Tests performed & treatment received: | |
| 33. Height _____ ft. / _____ in. Weight _____ lbs. | a. Has your weight changed by more than 10 pounds during the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N b. If "Yes," by how many pounds? _____ <input type="checkbox"/> Gain <input type="checkbox"/> Loss |

- | 34. | Age if Living & Health Status | Diabetes, Cancer, Heart Disease?
<i>(include age of onset)</i> | Age at Death & Cause |
|---------------|-------------------------------|---|----------------------|
| a. Father | | | |
| b. Mother | | | |
| c. Sibling(s) | | | |
| | | | |

35. **Details:** *(List details from questions answered “Yes” and please specify to which question numbers details pertain.)*

SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process.
See Underwriting Guidelines for further details.)

| Proposed Insured B 1. (First, Middle, Last): | Date of Birth 2. (mm/dd/yy): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---------------------------------|--------------------------|-----|----|---|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--|--|--|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--|--|---|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--|--|---|--|--|
| <p>► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.</p> <table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>5. Have you ever had any indication of, or been treated by a licensed medical professional for:</td> <td></td> <td></td> </tr> <tr> <td>a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. Anemia, leukemia, clotting disorder or any other blood disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>k. Any disorder of the eyes, ears, nose or throat?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>l. Any mental or physical disorder medically or surgically treated condition not listed above?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>7. 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Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> | b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes? | <input type="checkbox"/> | <input type="checkbox"/> | c. Anemia, leukemia, clotting disorder or any other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder? | <input type="checkbox"/> | <input type="checkbox"/> | e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> | f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> | g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> | h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> | i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder? | <input type="checkbox"/> | <input type="checkbox"/> | j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin? | <input type="checkbox"/> | <input type="checkbox"/> | k. Any disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | l. Any mental or physical disorder medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.) | <input type="checkbox"/> | <input type="checkbox"/> | Type _____ Frequency _____ Amount _____ | | | 8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not? | <input type="checkbox"/> | <input type="checkbox"/> | 9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics? | <input type="checkbox"/> | <input type="checkbox"/> | 10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements. | | | 11. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.) | | |
| | Yes | No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Anemia, leukemia, clotting disorder or any other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| k. Any disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| l. Any mental or physical disorder medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type _____ Frequency _____ Amount _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics? | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

SECTION D - DEFINED AGE QUESTIONNAIRE

(Complete if either Proposed Insured is age 70 or over.)

1. Proposed Insured A (First, Middle, Last) _____

2. Proposed Insured B (First, Middle, Last) _____

| | Proposed Insured A | Proposed Insured B |
|--|---|---|
| 3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued? | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy? | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value? | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy? | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 7. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.) | | |

OWNER INFORMATION

| | Owner |
|--|---|
| 8. Owner Name _____ | |
| 9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Application Supplement.) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 13. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.) | |

SERVICE OFFICE ENDORSEMENTS (For Company Use Only. We will attach additional documentation as needed.)**SUITABILITY**

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

| | |
|--|---|
| 1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs? | <input type="checkbox"/> Y <input type="checkbox"/> N |

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify that the tax identification or social security number as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I (including Sections A-D if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I shall be complete when it includes Application Information - Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):

☐ Section A- Health Summary -Proposed Insured A, ☐ Section B- Applicant Information -Proposed Insured B,
☐ Section C -Health Summary -Proposed Insured B, and ☐ Section D - Defined Age Questionnaire.

2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

I/We have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms. (Please complete Temporary Life Insurance Agreement and submit with application.)

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AR, DC, KY, ME, NM, OH and PA Only. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

TRUST VERIFICATION

I/WE hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose information related to my insurability to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____
(state) (month) (year)

Signature of Proposed Insured A
(Parent or Guardian if under 14 years of age)

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? ☐ Y ☐ N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Y ☐ N

If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

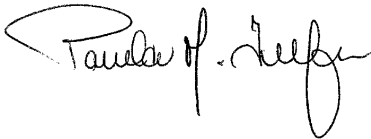
ARKANSAS

Certification of Compliance

The Lincoln National Life Insurance Company

**RE: TRM5065 – Individual Term to Age 95 Life Insurance Policy
with Policy Data Pages F5165-10, F5165-15, F5165-20 & F5165-30**

We do hereby certify that the guidelines outlined in Bulletin 11-83 have been reviewed and that our Form(s) Listed Above, does (do) hereby comply with these guidelines.

A handwritten signature in black ink, appearing to read "Pamela M. Telfer". The signature is fluid and cursive, with a large initial "P" and a long, sweeping underline.

Pamela M. Telfer
Assistant Vice President Product Compliance

Date: November 10, 2008

STATEMENT OF POLICY COST AND BENEFIT INFORMATION
IMPORTANT INFORMATION TO POLICYHOLDERS

DATE: FEBRUARY 1, 2009
INSURED: JOHN DOE
AGE AND SEX: 35 MALE
POLICY NO: LN123456789
POLICY CLASS: STANDARD NON-TOBACCO

FOR INFORMATION CONTACT:
THE LINCOLN NATIONAL
LIFE INSURANCE COMPANY
P.O. BOX 21008
GREENSBORO, NC 27420-1008
TELEPHONE: 800-487-1485

PAGE 1 OF 2

AGENT:
LINK N. LIFE
100 MAIN STREET
ANY CITY, NH 99999

| FORM NUMBER | BASIC BENEFITS | AMOUNT OR UNITS | MATURITY OR DATE OF EXPIRY | PREMIUM |
|----------------|---|--------------------|-------------------------------|---------------|
| TRM5065 | TERM LIFE INSURANCE TO ATTAINED AGE 95 (NON-PARTICIPATING) – CONVERSION PERIOD WITHIN THE FIRST 15 POLICY YEARS AND PRIOR TO ATTAINED AGE 70. | \$100,000.00 | FEBRUARY 1, 2069 | SEE NEXT PAGE |

STATEMENT OF POLICY COST AND BENEFIT INFORMATION
IMPORTANT INFORMATION TO POLICYHOLDERS

DATE: FEBRUARY 1, 2009
INSURED: JOHN DOE
AGE AND SEX: 35 MALE
POLICY NO: LN123456789
POLICY CLASS: STANDARD NON-TOBACCO

FOR INFORMATION CONTACT:
THE LINCOLN NATIONAL
LIFE INSURANCE COMPANY
P.O. BOX 21008
GREENSBORO, NC 27420-1008
TELEPHONE: 800-487-1485

PAGE 2 OF 2

AGENT:
LINK N. LIFE
100 MAIN STREET
ANY CITY, NH 99999

TERM LIFE INSURANCE
EFFECTIVE DATE: FEBRUARY 1, 2009

| *****ANNUAL PREMIUMS***** | | *****BENEFITS***** | |
|---------------------------|----------------------------|-------------------------|--|
| POLICY YEAR | TERM LIFE INSURANCE POLICY | TERM LIFE DEATH BENEFIT | |
| 01 | \$233.00 | \$100,000.00 | |
| 02 | 233.00 | 100,000.00 | |
| 03 | 233.00 | 100,000.00 | |
| 04 | 233.00 | 100,000.00 | |
| 05 | 233.00 | 100,000.00 | |
| 06 | 233.00 | 100,000.00 | |
| 07 | 233.00 | 100,000.00 | |
| 08 | 233.00 | 100,000.00 | |
| 09 | 233.00 | 100,000.00 | |
| 10 | 233.00 | 100,000.00 | |
| 11 | 233.00 | 100,000.00 | |
| 12 | 233.00 | 100,000.00 | |
| 13 | 233.00 | 100,000.00 | |
| 14 | 233.00 | 100,000.00 | |
| 15 | 233.00 | 100,000.00 | |
| 16 | 233.00 | 28,163.90 | |
| 17 | 233.00 | 28,163.90 | |
| 18 | 233.00 | 28,163.90 | |
| 19 | 248.21 | 28,163.90 | |
| 20 | 268.20 | 28,163.90 | |
| | | | |
| AGE | | | |
| 60 | 421.70 | 28,163.90 | |
| 65 | 677.43 | 28,163.90 | |
| 70 | 1,013.98 | 28,163.90 | |

GUARANTEED VALUES
10TH YEAR 20TH YEAR

| | | |
|---------------------------|------|------|
| SURRENDER COST (SC) INDEX | 2.33 | 2.67 |
| NET PAYMENT (NP) INDEX | 2.33 | 2.67 |

AN EXPLANATION OF THE INTENDED USE OF THESE INDEXES IS PROVIDED IN THE LIFE INSURANCE BUYER'S GUIDE.



Lincoln Financial Group
One Granite Place
P.O. Box 515
Concord, NH 03302
phone 603 226-5000

November 21, 2008

Hon. Julie Benafield Bowman
Commissioner of Insurance
Compliance-Life & Health
Attn: Joe Musgrove
1200 West Third Street
Little Rock, AR 72201-1904

Re: Individual Term Life Insurance Policy Forms
TRM5065; Term to Age 95 Life Insurance Policy
F5165-10; 10-Year Level Term to Age 95 Policy Data Pages
F5165-15; 15-Year Level Term to Age 95 Policy Data Pages
F5165-20; 20-Year Level Term to Age 95 Policy Data Pages
F5165-30; 30-Year Level Term to Age 95 Policy Data Pages
Group & NAIC #: 020-65676

Dear Mr. Musgrove:

We are submitting the required number of copies of the above-referenced forms for your review and approval. These are new forms and will not replace any forms previously approved by your Department. This product is a Term to Age 95 Life Insurance Policy with the specimen Policy Data Pages for 10, 15, 20 and 30-year level term periods.

This individually underwritten policy will be marketed through properly licensed agents in the general insurance market. The minimum face amount is \$100,000 and the face amount may not be increased or decreased after issue. However, the face amount will be contractually decreased following the end of the level term period e.g. a 10 year level term policy would have a face amount decrease in policy year 11. Cost of insurance rates are banded by face amount. The premiums as shown on the policy data pages are guaranteed at issue and are not subject to increase or decrease for in-force policies. The issue ages are: 18-75 for the 10-year; 18-65 for the 15 year; 18-60 for the 20 year; 18-50 for non-tobacco classes and 18-45 for tobacco classes for the 30 year term. The enclosed copy of the policy contains the specimen Policy Data Pages for each term as noted above. At issue, the policy will only include the Policy Data Pages for the term elected. We will use application form LFF06321, which was approved on 06/16/2008 under State Filing No. 39195.

Please accept this as our assurance that we are in compliance with the requirements of Arkansas Code Ann. 23-79-138. We provide a document entitled "Important Information to Policyholders", which contains the required information. Also, please accept this as our assurance that we are in compliance with the requirements of Regulation 49 and we provide the required Guaranty Association notice.

We have bracketed certain items in the forms as variable information because they may change for new issues in the future (but not in-force policies). These items include: officer names/signatures and the service office address, all premiums, policy fee, conversion period, modal factors and any information that varies based on the insured. It is our understanding that changes to the bracketed items for new issues will not require a new filing of these forms. We confirm that the brackets will not actually appear on the forms at issue.

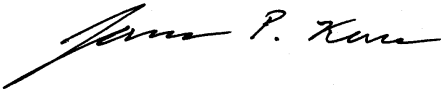
www.lfg.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates

When combined, the Policy and Policy Data Pages achieve a Flesch score of 55.43. This form is being submitted concurrently to our domicile state of Indiana and is pending approval. These forms will not be marketed with an illustration. The appropriate certification(s), transmittal, and filing fee are included, as applicable. To the best of our knowledge and belief, this filing complies with all the laws and regulations of your State.

We trust the information provided is satisfactory and look forward to your response. Unless submitted electronically, a postage-paid envelope has been enclosed for your convenience in corresponding with us. Should you require additional information, please feel free to contact me toll-free at 1-800-258-3648, ext. 5426, by fax at 1-603-226-5128 or via e-mail at the address shown below.

Sincerely,

A handwritten signature in black ink, appearing to read "James P. Kane". The signature is fluid and cursive, with a long horizontal stroke extending to the left.

James P. Kane
Analyst, Life Product Compliance
Email: James.Kane@LFG.com